MASSACHUSETTS GENERAL HOSPITAL

MAGNETIC RESONANCE IMAGING (MRI) PATIENT PROCEDURE SCREENING FORM

Massachusetts General Hospital Imaging

Date ____ / ____ / ____ MGH Medical Record Number ______________________

Name ______________________________ Age________ Height__________ Weight__________
Last Name First Name Middle Initial

Date of Birth ____ / ____ / ____ ❒ Male ❒ Female

Body Part to be Examined ______________________ If applicable, which body part? ❒ Left ❒ Right

Reason for MRI and/or Symptoms ______________________________

WARNING

Certain implants, devices or objects may be hazardous to you and/or may interfere with the MRI procedure (i.e., MRI, MR Angiography, functional MRI, MR spectroscopy). **Do Not Enter** the MRI scan room or MRI environment if you have any questions or concerns regarding an implant, device, or object. Always consult the MRI Technologist **BEFORE** entering the MRI scan room.

❒ Yes ❒ No Do you have a Pacemaker, Pacing Wires, ICD (Implantable Cardioverter Defibrillator)
❒ Yes ❒ No Brain Aneurysm Clip(s) — If Yes - Date of Surgery____________ Name of Hospital ______________________
❒ Yes ❒ No Cochlear, otologic or other ear implant/surgery

❒ Yes ❒ No Have you received dialysis for kidney/renal failure
❒ Yes ❒ No Do you have any of the following conditions, If **YES** mark what you do have:
❒ Kidney diseases / surgery ❒ Diabetes ❒ Lupus ❒ Multiple Myeloma ❒ Acute Kidney Injury

1. Do you have a personal history of cancer? ❒ Yes ❒ No
 If Yes, what type: ______________________
2. Have you had a MRI before? ❒ Yes ❒ No
3. Have you had contrast injected today for any other exam? ❒ Yes ❒ No
4. Can you lie flat for at least 45 minutes? ❒ Yes ❒ No
5. Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind? ❒ Yes ❒ No
 If yes, please indicate the date and type of surgery:
 Date ____ / ____ / ____ Type of Surgery ______________________
 Date ____ / ____ / ____ Type of Surgery ______________________
6. Are you currently taking, or have you recently taken any medication/drugs? ❒ Yes ❒ No
 If yes, please list: ______________________
7. Are you allergic to any medications/drugs? ❒ Yes ❒ No
 If yes, please list: ______________________
8. Have you ever had a reaction to contrast material or "dye" used for an MRI, CT or X-Ray Examination? ❒ Yes ❒ No
 If yes, please explain: ______________________
9. Do you have a history of asthma, seasonal allergies, allergic reactions, or respiratory disease? ❒ Yes ❒ No
 If yes, please explain: ______________________
10. Do you have anemia or any disease(s) that affect the blood? ❒ Yes ❒ No
 If yes, please describe: ______________________
11. Do you have claustrophobia or anxiety regarding your MRI examination? ❒ Yes ❒ No
 If yes, please explain: ______________________
12. Do you have Breast Implants? ❒ Yes ❒ No
 If Yes, ❒ ***Saline*** ❒ ***Silicone***

For female patients:

13. Date of last menstrual period: ____ / ____ / ____ ❒ Peri-menopausal ❒ Post Menopausal
14. Are you pregnant or is there any chance that you could be pregnant? ❒ Yes ❒ No
15. Are you experiencing a late menstrual period? ❒ Yes ❒ No
16. Are you currently breast-feeding? ❒ Yes ❒ No
17. Do you have an IUD, Diaphragm or Pessary? ❒ Yes ❒ No
 If yes, what type: ______________________
18. Are you receiving hormonal treatment? ❒ Yes ❒ No
 If yes, please describe (Tamoxifen, Aromatase Inhibitors, etc): ______________________

Please indicate if you have any of the following:

- ❒ Yes ❒ No Injury or removal of a metallic object/fragment from the **eyes** (e.g. metallic sliver, shavings, foreign body etc.)
- ❒ Yes ❒ No Injury by a metallic object or foreign body (e.g. BB, bullet, shrapnel, etc.)
  If yes to either of the above questions please describe ______
- ❒ Yes ❒ No Brain surgery involving metal clips or implants – If yes, what type ______
- ❒ Yes ❒ No Shunt (Spinal or Intraventricular) – If yes, what type ______
- ❒ Yes ❒ No Internal Electrodes or Wires
- ❒ Yes ❒ No Heart valve prosthesis – If yes, what type ______
- ❒ Yes ❒ No Metallic stent, filter, aneurysm coil, clip or graft – If yes, what type ______
- ❒ Yes ❒ No Vascular Access Port and/or Catheter ❒ Standard ❒ Power
- ❒ Yes ❒ No Swan-Ganz or thermodilution catheter
- ❒ Yes ❒ No Electronic and/or magnetically activated implant or device – If yes, what type ______
- ❒ Yes ❒ No Any type of stimulator (neuro, spinal cord, bone growth, bone fusion, etc)
  If yes, what type ______
- ❒ Yes ❒ No Implanted insulin or other drug infusion device or pump – If yes, where ______
- ❒ Yes ❒ No Other Implant – If yes, please explain ______
- ❒ Yes ❒ No Bone or Joint pin, replacement, screw, nail, wire, plate, etc. – If yes, where ______
- ❒ Yes ❒ No Any type of prosthesis (artificial limb, penile, eye, etc) – If yes, where ______
- ❒ Yes ❒ No Surgical staples, clips, wire mesh or metallic sutures – If yes, where ______
- ❒ Yes ❒ No Radiation seeds or implants – If yes, where ______
- ❒ Yes ❒ No Eyelid spring, wire or weight – If yes, what type ______
- ❒ Yes ❒ No Tissue Expander (e.g., Breast)
- ❒ Yes ❒ No Dentures, partial plates, magnetic dental implant
- ❒ Yes ❒ No Medication Patch (Nicotine, Nitroglycerin, Pain, etc) **(Remove before entering MRI scan room)**
- ❒ Yes ❒ No Hair Wig or Extensions **(MAY need to be removed before entering MRI scan room)**
- ❒ Yes ❒ No Body piercing jewelry **(Remove all piercings before entering MRI scan room)**
- ❒ Yes ❒ No Hearing aid **(Remove before entering MRI scan room)**
- ❒ Yes ❒ No Tattoo or permanent makeup – If yes, where/when ______
- ❒ Yes ❒ No Breathing problems or motion disorder

IMPORTANT INSTRUCTIONS

You **must** change into hospital provided clothing. Ear plugs will be provided and must be worn during the examination. Before entering the MRI environment or MRI system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing, watch, safety pins, paperclips, money clips, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper and tools.

Please consult with the MRI Technologist if you have any questions or concerns BEFORE you enter the MRI scan room.

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form, and regarding the MRI procedure that I am about to undergo.

Signature of Person Completing Form: ______ Date: ___ / ___ / ___

Form Completed By: ❒ Patient ______ ❒ Nurse ❒ Relative ______
Print Name *Relationship to Patient*

MRI Staff Only

IV Inserted by: ______ IV Gauge/Type: ______ ❒ Left ❒ Right ______ *(Location)*

Creatinine Level: ______ Estimated Glomerular Filtration Rate (eGFR): ______ *(via eGFR calculator on MRI website)*

Power Injector filled by: ______ (Tech Initials) Lab Exam Date: ___ / ___ / ___ ❒ Criteria for checking labs not met

- *Patient's full name and Date of Birth (DOB) verified verbally with patient, exam form and ID band* ______ / ______ *(Tech Initials)*
- *Accession number(s) confirmed with requisition and scanner demographics* ______ / ______ *(Tech Initials)*
- *Patient allergies and/or contraindications to IV and/or oral contrast reviewed* ______ / ______ *(Tech Initials)*
- *Contrast Dose:* ______ *(mL) (Confirmed via dose calculator on MRI website)* ______ / ______ *(Tech Initials)*
- *Chest X-ray/CT images and report reviewed for potential Pacemaker/ICD - Exam Date:* ___ / ___ / ___ ______ / ______ *(Tech Initials)*
- *Pacemaker/ICD Present* ❒ *Yes* ❒ *No*
- *QPID Used* ❒ *Yes* ❒ *No* ❒ *Not Available* ______ / ______ *(Tech Initials)*

Reviewed By: ______ ______
Print Name MR Technologist Signature

Secondary Technologist: ______ ______
Print Name MR Technologist Signature